

Problem

Healthy people are vital to economic and social development. Although the country has made significant progress in improving the health of its population, the statistics on India's fertility rates, HIV and infectious disease burden and child survival point to the need for continued investments to expand programs, identify new models for intervention, and develop approaches to ensure sustainability. Failure to address the unmet need for family planning and reproductive health, increasing HIV transmission, and a significant burden of child mortality could plunge India into a downward spiral of political instability, decreased economic growth, environmental degradation, and an unmanageable burden of disease.

Population Growth and Reproductive Health

On May 11, 2000, India's one-billionth citizen was born. More than 70,000 children are born daily, representing 17 million more Indians annually. Nearly a third of the population has yet to reach puberty. With a growth rate of 1.9% per year, India will surpass China in the next 50 years as the world's most populous country, and by 2070 the population could exceed 2 billion. Furthermore, India's enormous population of young people will require reproductive health services over the next 10-15 years. Large numbers of couples want to space or limit births but they are not using any method of contraception. Nationwide, approximately 16% of couples or about 30 million couples have an unmet need for contraception¹. High fertility is one important factor affecting the reproductive health of women. One out of every 75 women of reproductive age dies from childbirth-related causes. Other reproductive health indicators also reflect poor health status. Only 15% of mothers receive complete antenatal care, and only 58% receive any iron/folate tablets or syrup. Only 34% of deliveries take place in facilities, and, at best, 42% are assisted by a health professional.

India's voluntary family planning program (the world's oldest) has achieved important results over the last 30 years. Knowledge of reproductive health has increased dramatically; nationally, contraceptive use by women of reproductive age increased in the past six years alone from 41% in 1992-93 to 48% in 1998-99; and the average number of children per family has dropped by over 40% (from 5.2 to 2.9) from 1972 to 1998-99. The target for 2010 is 2.1 children per family, with a growth rate of 1.2% per year.

There are important differences between north and south India. Several southern states (e.g., Kerala and Tamil Nadu) have almost stabilized their population growth and the others are making good progress. In the northern states (particularly Uttar Pradesh, Bihar and Rajasthan), population growth rates hover around 2.3%, as compared to the national average of 1.9%. Unmet need for family planning is high in these northern states and about 25% of it is in Uttar Pradesh (UP). Other reproductive health indicators are uniformly worse in the northern states than the national averages.

¹ National Family Health Survey (NFHS) 1998-99

HIV and Other Infectious Diseases

HIV and other infectious diseases, such as polio and tuberculosis, present significant public health challenges for India.² Nationwide 0.9% of adults in India are infected with HIV; however, this represents over five million infected people, a number second only to South Africa. These statistics mask the substantial variation in HIV prevalence among states, many of which have populations that are larger than most nations in the world. For example, the states of Maharashtra and Tamil Nadu have a combined population of over 159 million and have registered HIV rates around 1% among pregnant women. Moreover, HIV is beginning to reach rural areas in high prevalence states.

Major bastions of polio exist in the UP and Bihar, and although eradication efforts have shown success, vigilance must be maintained to eliminate the virus. Eradicating polio remains a national and global priority.

India accounts for an estimated one third of the global burden of tuberculosis (TB). It is the leading disease in India, killing more than 1,000 people a day. Every year, tuberculosis results in 300,000 children leaving school, 100,000 women being rejected from their families, and economic costs to society of approximately \$3 billion. These staggering figures will get worse with the spread of HIV and multi-drug resistant tuberculosis, unless urgent action is taken now. India is taking action; the Revised National Tuberculosis Control Program (RNTCP) is expanding rapidly. RNTCP is being implemented in the phased manner in the country. By Dec 2003, more than 75% of the country has been covered under DOTS, however, the entire country needs to be covered.

Child Survival

The burden of child mortality and morbidity in India is tremendous.³ Over 20% of child mortality worldwide occurs in India. More than two million children die annually from preventable and curable infectious diseases and other causes. With infant mortality at 70 per 1,000 live births, and under-five mortality at 101 per 1,000 live births, India ranks 49th in under-five mortality, similar to Ghana, Swaziland and Nepal. Over 70% of child mortality occurs during infancy. Neonatal and peri-natal mortality (death within the first month of life) is responsible for about 60% of infant mortality.⁴

Under nutrition is associated with over 50% of childhood deaths, and directly affects the severity of diseases such as measles, and diarrhea. Although severe malnutrition has dropped significantly over the past 30 years, today 59% of rural and 48% of urban households do not consume the recommended number of calories, and, in rural areas, the daily per capita calorie intake has decreased in most states since the 1970s. The impacts are reflected in child health statistics, high anemia levels, and high levels of maternal undernutrition. The causes of undernutrition include delayed initiation of breast-feeding, early termination of exclusive breast-feeding, low vitamin A intake, and inappropriate complementary feeding practices.

Continued improvements in child survival have been demonstrated over the past 15 years, as evidenced by a decline in under-five mortality rates. Similar to the statistics on fertility and reproductive health, clear differences in child mortality exist by state, gender, economic status

² Measles, pneumonia, diarrhea and tetanus are also prominent infectious diseases, but as primarily killers of children, are addressed in child survival efforts.

³ It is estimated that over 240,000 and 140,000 children die from measles and tetanus, respectively, in India annually. About 1.2 million die from either diarrhea or respiratory disease.

⁴ Major causes of neonatal mortality include asphyxia, birth trauma, hypothermia, acute respiratory infection, and diarrhea. In some northern states, neonatal tetanus remains an important killer in specific blocks where routine immunizations are low. For example, in 2000, although tetanus (TT) coverage increased from ~37% in 1992-93 to ~51% in 1998-99 Uttar Pradesh, 49% of infants remain unimmunized and at potential risk. According to the National family Health Survey -2, full immunization coverage for UP is estimated at 22%.

and location, with the highest rates and greatest need in the northern states. The discrepancy of vital statistics between the north and south presents a public health imperative to state and federal decision-makers, as child survival is an issue of national concern and pride.

In sum, overcoming obstacles to better health is vital to completing India's development agenda. Although progress has been significant for all major health areas, substantial gaps remain and constitute an unfinished agenda for the country's health sector. Disparities among states, and the health status of growing numbers of urban poor need to be effectively addressed.⁵ By 2015, 50% of India's population is likely to live in urban areas, up from 30% today, and fully 50% may live below the poverty line.

Constraints

The capacity of the public sector to meet the health care needs described above remains severely limited. While much progress has been made, substantial changes are required to ensure access to adequate information and services, and the sustainability of improved services and systems, particularly in the northern states of India.

Currently, only around 5% of GDP is spent on health (equivalent to the middle 20% of countries worldwide); public sector health expenditures are 0.9% of GDP (less than 4% of total government spending—equivalent to the bottom 10% of countries worldwide).⁶ Less than 10% of Indians have access to any health insurance. Salaries consume a large percentage of public sector recurrent costs, even though severe staff shortages exist at national and state levels. The number of basic service providers has not kept pace with population growth, yielding a 30-50% shortage in coverage, mostly for rural populations. Hospitals receive over half of public sector resources. Obtaining and maintaining equipment is difficult. Distribution systems for equipment and drugs are poor, and stockouts of basic medicines and supplies occur frequently. The demand for resources by other sectors, notably for subsidies in the power sector, limits opportunities for improved health care financing.

Stagnant, inefficient public sector spending impedes services and results in huge and increasing out-of-pocket spending for private sector health care. As the economic growth strategic objective works to increase financial stability, the health SO will help government target the savings into social services. The public sector health system is “pro-rich” in that the richest 20% of the population benefits from over 33% of the public sector funding for curative services. For Indians below the poverty line, the public sector remains the critical source for preventive and basic health services, even though services are generally poor and accessibility is limited (i.e., the public sector provides 93% of immunizations, 74% of antenatal care, and 69% of institutional deliveries). However, about 80% of outpatient care is provided by the private sector.⁷ As in most developing countries, richer households purchase more curative care from the private sector than do poorer households.

Poor management of public services at all levels is reflected in a range of deficiencies. Public sector resources are not effectively targeted to serve the poor. Outreach to the most vulnerable elements of the population is very limited, and the quality of services, in general, is poor. Health information for clients and providers needs to be updated and more broadly disseminated. Human and fiscal resources are often ill-applied and inadequate, and thus, impede service delivery.

⁵ Child mortality rates in urban areas continue to be lower than in rural areas. However, over the last ten years, more rapid declines have occurred in rural areas. This finding reflects an increased proportion of urban poor, especially indigent migrant workers and slum dwellers, in India.

⁶ This puts India in the category of countries emerging from recent conflicts, such as the Republic of Georgia, Cambodia and Myanmar.

⁷ These fiscal and system statistics were obtained from the World Bank report: “India—Raising the Sights: Better Health Systems for India's Poor,” May 2001.

Additional constraints exist in the delivery of services. For family planning, the choice of methods is often limited and sterilization remains the method of choice. Other approaches, including delaying the age of marriage and first pregnancies, and encouraging longer birth intervals, present major social and programmatic challenges. Religious and medical barriers exist in some areas, as do cultural issues associated with the preference for boys and denial of opportunities for girls and women.

Although federal authorities are concerned about the HIV/AIDS epidemic, the level of effective commitment (e.g., fiscal and institutional) to prevention at the state level varies. Few NGOs have the capacity to carry out effective, sizeable interventions. Scaling up prevention efforts will require mechanisms for capacity building at all levels, in both the private and public sectors, and in urban and rural areas. The stigma associated with HIV infection must be reduced in all segments of society. HIV surveillance needs strengthening and voluntary testing and consultation need to be expanded. TB therapy represents an important operational and financial challenge given poor patient compliance, drug management, and the cost of the drugs.

Although the private sector is a major source of services (particularly curative), the public sector has limited scope for engaging the private sector (NGO and commercial sector) and ensuring an adequate quality of care. As a result, the private sector is considerably under-exploited and under-supervised in the promotion and provision of preventive health services, including family planning, child health and other public health interventions.

Neither the public nor the private sector alone can address all of the health problems and unmet need in India. Both sectors have their strengths and comparative advantages as well as limitations. To meet short and longer term health needs, the public sector must more effectively exploit all opportunities to engage the private sector (i.e., NGO and private industry). New paradigms for public-private partnerships and service delivery must be developed and embraced, at the state level, to ensure equity, accountability, quality and affordability of health services.

Rationale

USAID India's Health Strategic Objective is consonant with the Agency's Global Health pillar and consistent with GOI policy. It builds on USAID experience during the strategy period 1994-2002; emphasizes areas of comparative advantage; and, given resource constraints, targets key geographic and program areas to meet the greatest need. The SO expands the previous program objective into a four-pronged approach that targets reproductive health, HIV prevention, child survival and tuberculosis control. This direction has been confirmed through in-house and external discussions with counterparts in government and the donor community.

Achievement of this SO will help meet USAID's longer-term goal (10-15 years) of building replicable and sustainable strategies (i.e., service delivery models that can be effectively scaled up and sustained through local resources) for meeting priority health needs. The longer term vision has informed the selection of sites and expansion, as well as inclusion of systems strengthening activities aimed to ensure eventual maintenance and sustainability for the longer term.

As India faces the mounting challenges of the 21st century, the improved delivery of reproductive, maternal and child health, and preventive HIV and TB services are of paramount importance to the Government of India. In its National Population Policy of 2000 and its new draft National Health Policy, the GOI sets ambitious goals and objectives for key health indicators and identifies a wide range of interventions. This SO and its strategic approach are

fully consistent with these policies and with the programming being carried out by the GOI and the respective state governments with which USAID proposes to work.

To help meet these challenges, this SO builds upon the service delivery platforms (systems, infrastructure, organizational arrangements and skills) developed and tested during the current strategy period, and targets geographic and programmatic expansion as described under "Geographic Focus."

Given the constraints of the public sector, under all of the IRs, the SO will explore and exploit as many opportunities as feasible with the private sector, NGOs and commercial industries to develop models for replication in targeted geographic areas. These models will rely on linkages and partnerships with public sector providers, facilities and managers. Therefore, the SO must, at the same time, strengthen the public sector in ways that will help it serve as an effective partner and regulator. USAID's resources, role and experience improve its ability to leverage major policy changes in the health sector. USAID will continue to collaborate closely with the World Bank and other influential donors to advocate for key policy changes. USAID will use its experience in India and its comparative advantage worldwide to address some critical, systemic problems.

The SO will support systems strengthening in the public sector to:

- Improve the capacity of states to make informed decisions;
- Support the development of improved logistic and commodity management;
- Address human resource needs, such as training and allocation;
- Strengthen quality assurance;
- Institute state and district planning for child and reproductive health;
- Help develop state policies for population, health and nutrition, and specific interventions, such as immunizations; and
- Where appropriate, assist states and the national level with accounts analyses that can lead to fiscal reform and improved efficiency.

The SO will also work with the public and private sectors to:

- Promote stronger and sustainable private-public sector partnerships;
- Develop demonstration models for private sector franchising;
- Develop and improve models of private sector service delivery through commercial providers and industrial and other commercial infrastructure;
- Develop and improve models for local NGO service delivery and sustainability; and
- Pilot implementation of strategies for health care financing through introduction of accounts analyses, user fees, corporate partnerships (franchising), insurance schemes and other health financing options.

The SO also proposes to promote scientific cooperation between Indian and US research and training institutions in the public and private sector. Potential areas of cooperation include HIV vaccine development, drug efficacy trials, vaccine efficacy trials, and operations research on various health interventions. To be developed in consultation with USAID Washington and the Embassy's Science Office, these multi-faceted partnerships can support achievement of SO objectives, nurture Indo-US cooperation over the short and long term, and improve local capacity to solve health sector problems in India.

Comparative Advantage

USAID's comparative advantage is its broad array of experience in both public and private sector health care interventions. In the priority technical areas, this comparative advantage has been used to determine the selection of interventions. These interventions will continue to be guided

by best practices and experience worldwide; needs in the specific geographic areas and among the target groups; and potential for impact and replicability.

Assumptions

Achievement of the SO is based on the following key assumptions. They will be monitored for their continued validity and relevance during program implementation, and will be updated, as appropriate.

- Political will at the state and national level will intensify for achieving progress in the health sector;
- State governments will embrace the private sector as a complementary entity to deliver basic preventive and curative services; and flexible engagement of the private sector will be encouraged;
- India's draft National Health Policy budget priorities will be realized, doubling public sector health expenditures by 2010;
- National and state authorities in the Ministries of Finance, Economic Development and Health/Family Welfare will embrace the Draft National Health Policy regarding improved health sector financing and pro-poor policies;
- Accountability for human and fiscal resources will improve significantly;
- The GOI will support more flexibility in using bilateral and unilateral resources for direct grants and contracts, thus decreasing the obligation-to-expenditure ratio and pipelines in the sector; and
- The USAID Title II program will continue at similar levels during the strategy period.

Target Groups

This SO targets the following broad sets of beneficiary groups, some key representatives of which were consulted in developing this strategy.

For the reproductive and child health activities:

- Women of reproductive age and their children less than five years old;
- Young and adolescent girls;
- Male family members;
- Care providers; and
- State, district, and block administrators.

For HIV prevention and control efforts:

- High-risk groups (such as female sex workers and their clients, including truckers and other men);
- Sexually transmitted infection (STI) clients;
- Women of reproductive age;
- Youth in general;
- Girls involved in trafficking;
- Men who have sex with men;
- Injectable drug users (perhaps); and
- Urban and rural family members for HIV information and preventive services.

For TB control:

- Members of the general population in Haryana (perhaps in Tamil Nadu and Maharashtra) who are diagnosed with TB.

For systems strengthening and public-private partnership activities:

- Managers and leaders in the public and private sectors at all levels.

Geographic Focus

India's large size and diversity, USAID's limited resources, and the availability of other donor resources in selected health sub-sectors and geographic areas, have influenced the selection of the SO's geographic expansion plans. USAID will focus on those states and districts having the greatest unmet needs for reproductive and child health services and the largest concentrations of high-risk groups for HIV/AIDS. These states have relatively less donor activity and support, and state leaders and officials are keenly interested in collaboration with USAID. Geographic focus will vary according to each intervention by:

- Building on reproductive and child health efforts in Uttar Pradesh (UP) and expanding family planning and reproductive and child health coverage to all 70 districts, reaching 170 million people;
- Expanding reproductive and child health efforts in Uttaranchal and Jharkhand, potentially servicing an additional 36 million people;⁸
- Continuing to focus HIV prevention and control activities on the high prevalence states of Tamil Nadu and Maharashtra, with expansion to Pondicherry, selected areas of UP, Uttaranchal, Jharkhand (with emphasis initially on those districts along truck routes and where other high risk groups are located), and perhaps in the northeastern states;⁹
- Integrating child survival, reproductive health and HIV/AIDS prevention¹⁰ by phases into the Title II program administered by CARE in six states—UP, Jharkhand, Chhattisgarh, Rajasthan, Madhya Pradesh, Delhi;¹¹
- Targeting children affected by AIDS activities in select cities and peri-urban areas (rather than a specific state focus);

⁸ USAID's involvement in Uttaranchal and Jharkhand has been agreed to during discussions with various government counterparts.

⁹ No efforts in the Northeast are planned at the time of this strategy, but options remain open. Future efforts in the Northeast must take into consideration security issues that presently impede action.

¹⁰ HIV/AIDS prevention activities are implemented in 22 urban areas.

¹¹ Add-on activities for Title II efforts will be supported with CSH funds.

- Focusing TB control in Haryana and potentially expanding efforts in Tamil Nadu.
- Testing the implementation of an integrated package of reproductive health, child survival and HIV prevention services through engagement with the municipalities, private sector and community organizations in the urban slum areas of Indore, Agra and Jamshedpur.

Impact Measurement

The success of the Health SO will be measured by the following illustrative indicators:

- Contraceptive Prevalence Rate;
- HIV sero-prevalence (Stabilized HIV prevalence rate <3.0%);
- Nutrition status of children under three years; and
- New smear positive pulmonary TB cases treated successfully.

Intermediate Results

IR 2.1 Increased Use of Reproductive Health and Family Planning Services

USAID will continue to work with the GOI to reorient and revitalize the country's family planning and reproductive health services, targeting the states of UP, Uttaranchal and Jharkhand as sites for demonstrating program innovations. Key interventions will include: promotion of birth spacing and effective use of contraceptives; counseling and provision of family planning and other reproductive health services and methods; and, expansion of outreach and access to services.

IR 2.2 Increased use of Prevention and Care & Support Interventions to Prevent/Mitigate HIV/AIDS

The Indian HIV epidemic is at an epidemiological crossroads. The window is open to contain the epidemic at relatively low infection rates through increased practice of safe behaviors, particularly in the most affected states of the country. USAID will continue to work with NGOs, private sector businesses, and the national and state governments to implement HIV prevention and control programs in targeted states. The strategy will also support national activities aimed at increasing knowledge of prevention and delivering effective STI treatment. Targeted interventions for high-risk groups will be pivotal elements of the strategy, but USAID will also pursue efforts to limit the spread to peri-urban and rural areas.

IR 2.3 Increased Use of Key Child Survival Interventions

Key child survival interventions include immunizations, breast-feeding, safe births, vitamin A distribution, supplementary feeding, and improved care-seeking behavior by mothers. Given the needs for improved neonatal care, emphasis will be given to addressing service delivery requirements for newborn and postnatal services. The application of these interventions will be pursued through USAID's existing Title II and IFPS programs, which, respectively, command an outreach to 110,000 and 45,000 villages.¹² Results from these programs are encouraging and significant potential exists for further child survival impact in a 5-10 year timeframe. Additional efforts will be pursued in targeted urban environments where poor, migrant, slum-dwelling populations present high rates of mortality and morbidity.

IR 2.4 Increased Use of Key Infectious Disease Interventions

Under this IR USAID plans to expand its current support for model TB delivery and research in Tamil Nadu and move into Haryana. USAID TB efforts focus on improving public and private sector delivery, and monitoring the effectiveness of diagnosis and treatment.

Relationship to Other Strategic Objectives

¹² If an average village size is estimated to include 1,000 inhabitants, outreach by these platforms will total about 155 million people and about 2 million children.

There are strong linkages between the health strategic objective and all other objectives in the strategy. Opportunities to work with the Economic Growth team on state accounts analysis, private sector engagement and fiscal policy relative to health will be identified and used during the strategy period. Rural linkages with the Energy-Water SO will be explored through the water-energy nexus relative to social mobilization and *panchayati raj* institution engagement for health. Coordination will continue with the US Embassy's Science, Public Affairs, Political Affairs, and Economic Affairs Sections; as well as the Center for Disease Control and Prevention (CDC) HIV/Infectious Disease Section and other US agencies.

Donor Coordination

During the development of this SO, USAID coordinated closely with other donors that are currently or may become engaged in targeted areas of assistance. This coordination will continue during strategy implementation to avoid duplication and maximize synergy.

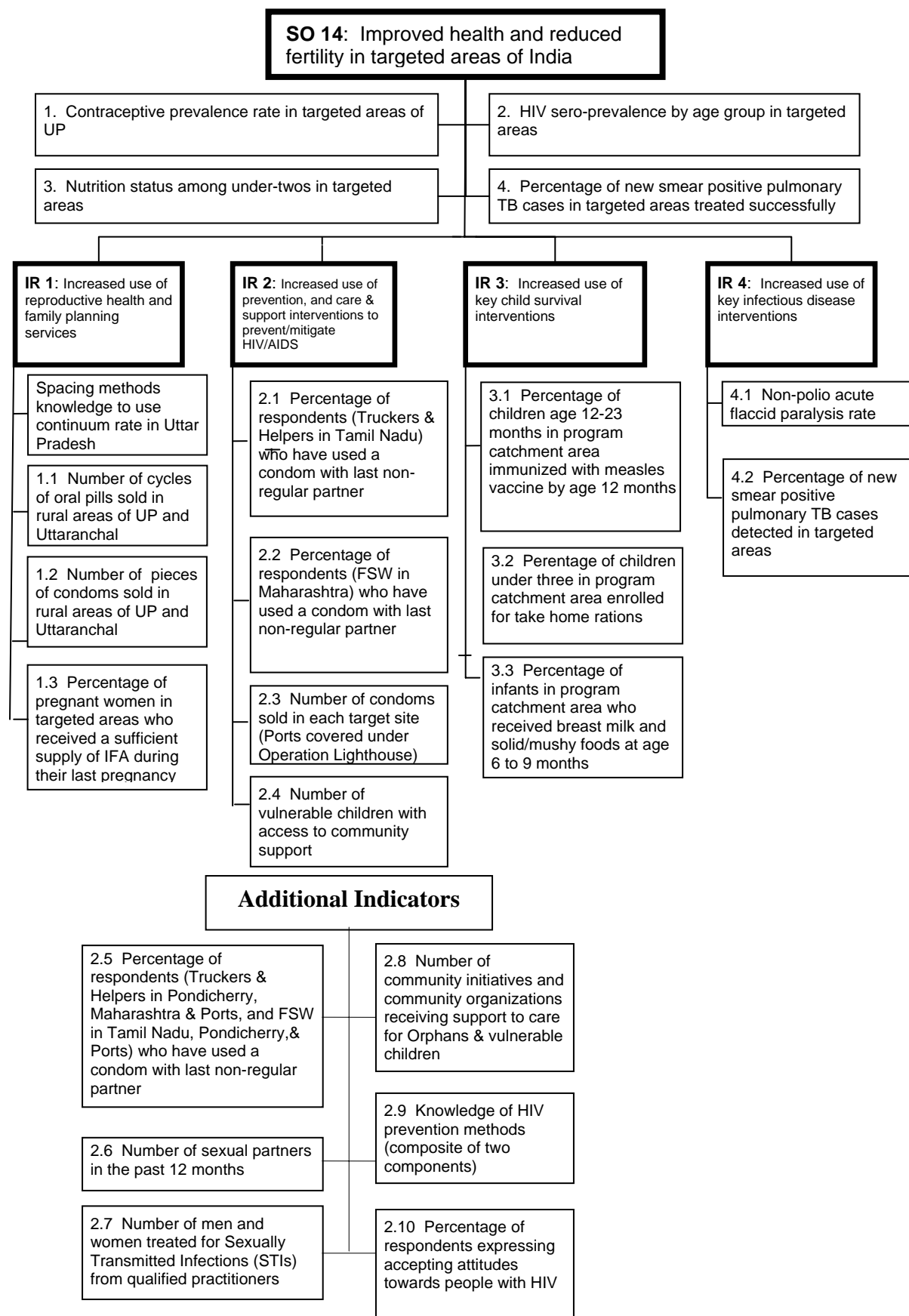
USAID is an influential partner in a number of government and donor committees. These include:

- National AIDS Coordinating Committee;
- UNAIDS Theme Group;
- National Polio Interagency Coordinating Committee;
- National Global Alliance for Vaccines and Immunizations Steering Committee;
- Rotary National Coordinating Group for Polio Eradication; and
- WHO Taskforce for Integrated Disease Surveillance.

USAID works closely with specific donors on a number of issues:

- The World Bank on surveillance and logistics management, advocating key policy changes, RCH II and HIV/AIDS;
- UNICEF on routine immunizations and vitamin A delivery in UP;
- WHO on surveillance and immunizations;
- CDC on HIV research and treatment of opportunistic infections;
- Rotary International on polio and expanded immunizations;
- Packard Foundation on reproductive health service delivery; and
- British Department for International Development (DFID) on polio eradication, RCH II and HIV prevention.

1.2 Strategic Objective 14 Results Framework



1.3 USAID Supported Health Activities in India

Although India has made significant progress in improving the health of its population, the statistics on India's high fertility rates, HIV and infectious disease burden, and child survival point to the need for further investments to expand programs, identify new models for intervention, and develop approaches to sustaining improvements. The Population, Health, and Nutrition (PHN) strategic objective of USAID/India, for the period 2003-2007, exemplifies an innovative approach of integrating three key health areas to accomplish one unified goal.

The Population, Health, and Nutrition objective of USAID/India is:

Improved health and reduced fertility in targeted areas of India through

- Increased use of reproductive health and family planning services;
- Increased safe behavior for HIV prevention, and increased use of key infectious disease interventions; and
- Increased use of key child survival interventions

These objectives are consistent with and support the Government of India's population and health policies and programs; build upon USAID's more than fifty years of experience in India; and target key geographic and program areas so as to meet the greatest need.

1.3 USAID Supported Health Activities In India

Tuberculosis

Priority state:
Haryana

HIV/AIDS

Priority areas:
Tamil Nadu,
Maharashtra,
Karnataka, Andra
Pradesh, Pondicherry &
12 Ports (★)

Other areas (☼):
Manipur, Nagaland,
Andhra Pradesh,
Uttar Pradesh &
Jharkhand

Polio

Nationwide with focus
on Uttar Pradesh &
Bihar

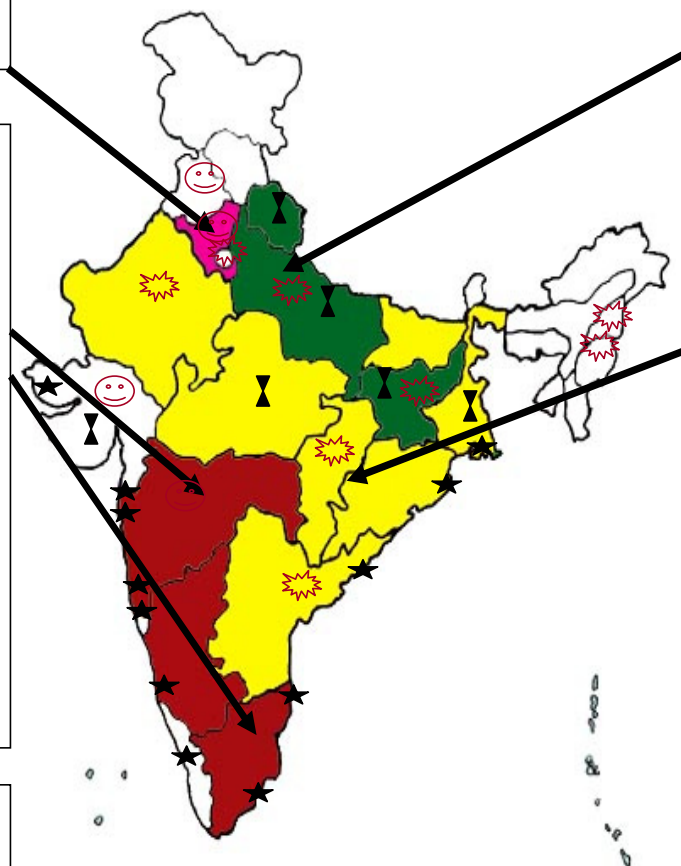
Reproductive and Child Health

Focus states:
Uttar Pradesh,
Uttaranchal &
Jharkhand

Other states:
Rajasthan, Madhya
Pradesh, Chhatisgarh,
Bihar, West Bengal,
Orissa & Andhra
Pradesh

Select areas (☺):
Maharashtra, Gujarat,
Delhi, Punjab &
Haryana

Urban Health in select
cities of Gujarat,
Madhya Pradesh,
Jharkhand & Uttar
Pradesh (▼)



SO 14 Team Structure

